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Supreme Court U.S.
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No. 02-852

In The

Supreme Court of the United States

FRANCES CLAY,

Petitioner,

versus

PROCTER & GAMBLE PAPER PRODUCTS COMPANY, PROCTER & GAMBLE, and Certain Subsidiaries, PROCTER & GAMBLE DISABILITY BENEFIT PLAN, PROCTER & GAMBLE BENEFIT PLAN TRUST,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

REPLY BRIEF

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REPLY BRIEF

Initially, it should be pointed out that there are several factual inaccuracies set forth by the Respondents in their Brief in Opposition to a Petition for Writ of Certiorari. Perhaps the most critical inaccuracy is that the Petitioner seeks to have this Court review the factual findings of the lower courts and to make a different determination regarding the weight and sufficiency of the evidence. As will be set forth more fully herein, Petitioner seeks to have this Court summarily reverse the decision of the district court, or to grant a writ of certiorari based upon the fact that the Eleventh Circuit's decision, which failed to address the ambiguities of the Plan and the Plan Summary language, was a violation of the requirements of ERISA, and based upon the fact that the decision of the Eleventh Circuit was in conflict with the decisions of other federal circuits which have held that providing to a plan beneficiary ERISA notice requirements, as specifically set forth therein, violates the express provisions of the statute and denies to federal courts the appellate review to which claimants are entitled, and that a review of the ERISA notice procedure is required. *Bartling v. Fruehauf Corp.*, 29 F.3d 1062 (6th Cir. 1994).

The Respondents misstate that the initial decision of the Trustees was not to grant to Mrs. Clay total disability status. In fact, the Trustees did initially place Frances Clay on total disability, as confirmed by the Trustees' letter to Mrs. Clay dated April 12, 1994 which states as follows:

> The Trustees have reviewed your letter dated March 9, 1994 and understand it is intended as an appeal of the Trustees' decision of January 25, 1994 to change your disability status from totally

> disabled to partially disabled as of December 14, 1993.

(R. 35, Exhibit 21)

It is also inaccurate to state that there is no authority, or that Petitioner has not set forth authority, for the argument that a Plan which contains provisions which are not in comport with the requirements of ERISA is a *per se* violation of the statute. Likewise, the Respondents misstate that the inadequacies and ambiguities in the Plan's provisions did not cause detriment to Mrs. Clay and her ability to successfully present her claim. Petitioner also shows that her physician did affirmatively state, even in her December 21 and December 22, 1993 Procter & Gamble Disability Plan Physician Certificates ("Physician Certificates") that she was indeed totally disabled. In fact, a review of Dr. John Baker's December 21, 1993 and December 22, 1993 Physician's Certificate reveals that he stated that Mrs. Clay was totally disabled (R. 35, Exhibit 13). Likewise Respondents misstate that Dr. Baker himself never concluded that Frances Clay could not undertake a Functional Capacity Assessment ("FCA"). In fact, a review of Dr. Baker's October 4, 1993 medical statement reveals that he certified that "Francis[sic] Clay is unable to do the FCA test . . . " (R.38, Exhibit 5).[1] Likewise it is a misstatement of the facts to state that Mrs. Clay's appeal (after she was awarded total disability by the Social Security Administration) was untimely, as set forth in her Argument of Appellant's Brief and Reply Brief.

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[1] This fact was pointed out to the Eleventh Circuit in the Appellant's Brief and Reply Brief.

I. NEITHER THE DISTRICT COURT NOR THE ELEVENTH CIRCUIT ADDRESSED THE PLAN PROVISIONS' DEFICIENCIES UNDER ERISA

The Respondents have argued that the Petitioner's dispute is not that the Trustees' interpretation of the Plan was unreasonable, but that the Trustees would not accept her physician's unsupported conclusion that she was totally disabled. The Respondents expend the first part of their opposition to the writ arguing that the Trustees were entitled to make decisions regarding the interpretation of the Plan, and that such decisions properly were reviewed by the district court and the Court of Appeals under the abuse of discretion standard. The Respondents also argue that the Petitioner has failed to identify any ambiguity in the Plan, or how her own interpretation would have resulted in a grant of total disability benefits. In making the foregoing argument, Respondents have failed to address the Petitioner's position that the Plan's provisions violated ERISA in not being written in a manner which could be understood by the average plan participant. See *Hansen v. Continental Insurance Company, Inc.*, 940 F.2d 971 (8th Cir. 1991) and *Hicks v. Fleming Cos.*, 961 F.2d 537 (5th Cir. 1992), and *Johnson v. Central States Southeast & Southwest Areas Pension Fund*, 513 F.2d 1173 (10th Cir. 1975).

The Petitioner argued that the Plan and Plan Summary do not define whether a person who cannot perform "useful duties" or "other duties" would be considered totally disabled, since the definition of partial disability states that one can perform these functions. Additionally, nowhere in the Plan are these terms defined. The salient question is this: if one cannot perform "useful duties" or "other duties," is one considered totally disabled? The

average plan participant is not apprised of whether, if his or her limitations fall outside the definition of partial disability, he or she would be considered by the Trustees as totally disabled. Furthermore, the key definitions of "useful duties" or "other duties" are not provided.

Respondents argue that Petitioner has failed to cite any authority for the proposition that if a Plan's provisions are ambiguous (and, therefore, arbitrary and capricious) such provisions are a *per se* violation of ERISA. Contrary to this assertion, ERISA itself provides the authority for this contention.

By the express terms of the statute, a plan description "shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C. § 1022(a). Respondents have completely ignored this express requirement, and indeed do not dispute the Petitioner's argument regarding her reasons for granting the writ based upon the ambiguities in the Plan under ERISA, and the lower courts' failure to address this issue.

II. THE DECISION OF THE DISTRICT COURT AND THE COURT OF APPEALS FAILED TO PROVIDE APPELLATE REVIEW OF THE PLAN'S NOTICE REQUIREMENTS

Respondents also argue that courts have required substantial, not strict, compliance with the provisions of 29 U.S.C. § 1133 and 29 C.F.R. § 2560.503(1)(f). In support of this contention, Respondents offer a line of cases represented by *Hancock v. Montgomery Ward Long Term Disability Trust*, 787 F.2d 1302 (9th Cir. 1986), *Kent v. United of Omaha Life Ins. Co.*, 96 F.3d 803 (6th Cir. 1996), and

Donato v. Metropolitan Life Ins. Co., 19 F.3d 375 (7th Cir. 1994). The Respondents fail to point out, however, that each federal circuit court of appeals in which such cases were heard has repeatedly held that the claims notice provisions set forth above are not merely to be followed at the discretion of the plan administrators, but should be adhered to for the purpose of beneficiaries having a fair opportunity to present their claims and to obtain meaningful appellate review – thus fulfilling the purposes of the ERISA requirements. *Matuszak v. Torrington Co.*, 927 F.2d 320, 323 (7th Cir. 1991), *Richardson v. Central States Southeast & Southwest Areas Pension Fund*, 645 F.2d 660, 665 (8th Cir. 1981). Unlike the cases cited by the Respondents, in no event did Mrs. Clay receive notice of what additional information she needed to provide to perfect her claim, or what specifically about her submitted information was inadequate. Furthermore, procedural errors can be significant if such errors apply or interpret the notice provisions of ERISA, or fairness requires that the administrator's decision be set aside. *Halpin v. W.W. Granger, Inc.*, 962 F.2d 685 (7th Cir. 1992).

Contrary to the conclusions urged by the Respondents, the Trustees did fail to follow the notification denial statutory requirements of ERISA, and such failures directly affected Petitioner's ability to successfully present her claim. Respondents argue, for instance, that Mrs. Clay never presented evidence that she was hospitalized or confined to the home, and that she never offered any additional supporting documentation to explain how her physician could certify that she could return to full time work but be considered totally disabled. Although Respondents argue that the Trustees explained the basis for their decision, a review of the notices provided by the Plan

Administrator reveals that not just one, but almost all of the notification requirements of 29 U.S.C. § 1133 and 29 C.F.R. § 2560.503(1)(f) were not followed.

The Respondents' argument misses the salient reason the Petitioner submits that this Court should grant a writ of certiorari to decide this case: neither the district court nor the Court of Appeals addressed the issue of whether the Plan's notification procedures adhered even substantially to the requirements under ERISA, despite the fact that Mrs. Clay (proceeding *pro se*) argued in her Plaintiff's Opposition to the Defendant's Motion for Summary Judgment that such notification requirements were not followed. The Seventh Circuit Court of Appeals explained the importance of adherence to such ERISA notification provisions by holding as follows:

> . . . describing additional information needed and explaining its relevance, as required by subsection (3) of 29 C.F.R. § 2560.503-1, enables a participant both to appreciate the fatal inadequacy of his claim as it stands and to gain a meaningful review by which to supplement the record.
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> *Wolfe v. J.C. Penney Co.*, 710 F.2d 388, 392 (7th Cir. 1983)

In the case at hand, if it is true, as now urged by Respondents' counsel in their opposition to the petitioner's writ of certiorari, that the Trustees needed supporting documents setting forth that Mrs. Clay had been hospitalized, or confined to her home, and/or that the Trustees required a further explanation from Mrs. Clay's physician regarding the December 1993 Physician's Certificates of her neurologist, and/or that they needed an explanation as to Mrs. Clay's performance in the Functional Capacity

Assessment demanded by the Plan administrators, this specific additional information should have been requested of Mrs. Clay in the Trustees' denial letters. Only now is the Trustees' desire to have this specific information being articulated – in direct violation of ERISA. See also *White v. Aetna Life Ins. Co.*, 210 F.3d 412 (D.C. Cir. 2000), wherein that court held that the Trustee's failure to articulate what specific additional information was needed was not in substantial compliance with ERISA.

At best, the Respondents can only argue that the Trustees' denial of Mrs. Clay's claims stated that the information she provided was insufficient; however, the Respondents have not pointed to, and indeed cannot point to, any denial of claim notification sent by the Trustees which describes what additional information she needed to provide to perfect her claim. Had Frances Clay been provided with an indication of what additional information the Trustees required from her, Petitioner could have likely obtained from one or more physicians a certificate that she was hospitalized and/or confined to her home; she, additionally, could have obtained from her physician an explanation as to what he meant in her two December 1993 Physician's Certificates when he indicated that Mrs. Clay was both totally disabled and could return to work with the extensive restrictions he set forth in such certificates. Instead of specifying what additional information they needed, the Trustees simply continued to state that the additional information Mrs. Clay provided was not sufficient. The Respondents' argument that such courts *did* review the Trustees' claim procedure simply is not supported by the record. Moreover, neither the district court nor the Court of Appeals addressed these procedural

deficiencies, rendering appellate court review of ERISA requirements meaningless.

CONCLUSION

Petitioner seeks summary reversal, or to have this Court accept her writ of certiorari, to correct a critical deficiency of the Eleventh Circuit Court of Appeals in failing to address the critical ambiguities in the Plan and Plan Description which did not reasonably apprise participants of their rights and obligations, thus rendering enforcement of ERISA hollow. Additionally, Petitioner seeks summary reversal or to have this Court accept her writ of certioarari to determine whether federal courts have an obligation to review an ERISA Plan Administrator's notice claims process to determine if such procedures failed to provide to plan participants information regarding the perfection of their claim and appeal in accordance with the requirements of ERISA. For the above and foregoing reasons, this court should either summarily reverse the judgment of the lower courts or grant the Petitioner's Petition for Writ of Certiorari.

Respectfully submitted,

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